

Bureau of Developmental Disabilities Services

Service Definition and

Standards for Wellness Coordination

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INTRODUCTION

The Bureau of Developmental Disabilities Services (BDDS) developed this document as a guide to Wellness Coordination for entities that have been approved by the Division of Disability and Rehabilitative Services (DDRS) Provider Relations program area. This document lists the standards for Wellness Coordination Services as well as the criteria established by the [service definition](#) and [460 IAC 6](#).

OVERVIEW OF WELLNESS

Wellness Coordination Services refers to the development, maintenance and routine monitoring of the waiver participant's Wellness Coordination Plan and the medical services required to manage his/her health care needs.

Wellness Coordination Services are to be provided by a registered nurse (RN) or a licensed practical nurse (LPN) under IC 25-23-1 working under the supervision of an RN.

Wellness Coordination Services extend beyond those services provided through routine doctor/health care visits required under the [Medicaid State Plan](#) and are specifically designed for participants requiring the assistance of an RN/LPN to properly coordinate their medical needs.

Wellness Coordination Services are for participants assessed with health scores of 5 or higher through the ICAP process. Participants assessed with health scores of 0-4 would not require assistance of an RN/LPN to coordinate medical needs.

EXPLANATION OF HEALTH SCORE

The ICAP assessment determines an Individual's overall level of functioning for Broad Independence and General Maladaptive Factors. The ICAP Addendum is a separate set of questions that determine an individual's level of functioning of behavior and health factors.

For health factors, both the frequency and intensity of the individual's health care needs are scored separately. The frequency and intensity scores are then added together to arrive at the "total" health score. For example, if the frequency score is 4 and the intensity score is 5, the total health score is 9. An individual qualifies to receive Wellness Coordination Services based on their total health score.

Participants assessed with health scores of 5 or higher through the State's objective based allocation process are eligible for Wellness Coordination Services. There are three (3) tiers of Wellness Coordination Services. Each tier has a different requirement for RN/LPN involvement. The health scores equate to the following tiers:

TIER REQUIREMENTS

Health Score Range 5-6

Tier I: Health care needs require at least one weekly (Sunday - Saturday) consultation/review by RN/LPN including face to face visits once a month. One of the face to face visits per month can count as a consultation. For example, 3 consultations and 1 face to face visit each month are required.

Health Score Range 7-9

Tier II: Health care needs require at least one weekly (Sunday - Saturday) consultation/review by RN/LPN including face to face visits at least twice monthly. One of the face to face visits per month can count as a consultation. For example, 3 consultations and 2 face to face visits each month are required.

Health Score Range 10

Tier III: Health care needs require at least twice weekly (Sunday - Saturday) consultation/review by RN/LPN including face to face visits once a week, regardless of the number of weeks or partial weeks within the month. Due to the high health and wellness needs of individuals in this tier there would be two consultations every week and one face to face visit every week. For example, 2 consultations and 1 face to face visit every week are required.

As medical events occur and/or a participant's medical needs change, the Individualized Support Team (IST) is expected to have the individual's health score reassessed and to ensure the appropriateness of services. If a team believes that an individual's health score is incorrect they should work with the entire team to submit a [Budget Review Questionnaire](#) (BRQ) to BDDS requesting a review of the individuals Algo Score. The case manager will submit the BRQ based on the team's agreement and recommendation.

WELLNESS COORDINATION SERVICES

Consultations and face to face visits are direct services. For face to face visits this requires the nurse to meet one on one with the individual (group visits are not allowable). Consultations with professionals or the IST can take place in person or through other communications. It should be noted that consultations and face to face visits are allowed while an individual is hospitalized for a short period of time as a unit is billed monthly.

FACE TO FACE VISITS

In implementing Wellness Coordination, face to face meetings are to occur per the tier requirements directly with the individual when discussing their diagnosis, prognosis, and treatments (as well as discussing weight, BMI and other measures) and must be documented in the individual's records to count as the face to face/consultation with the individual. Face to face meetings must take place individually; not in group settings with several individuals receiving the same service from the Wellness provider.

Face to face meetings may also occur in a home or community based setting where the individual commonly spends time. It is expected the nursing visits involving observations and assessments of the individual will take place in the natural environment of the individual to accurately establish and document how their environment is affecting their wellness.

CONSULTATIONS

Ongoing consultations should take place with the individual's health care providers and the IST. A consultation is defined as a conversation of two or more individuals to discuss the diagnosis, prognosis, and treatment of a particular case. While consultations can take place in person or by other means of communication, documentation must clearly show a collaborative discussion has taken place. One of the face to face visits per month that takes place with the nurse can also count as a consultation with the individual. Examples of consultations include:

- Discussion with health care professionals about the individual health status
- Discussion with Direct Support Professional's (DSP's) in regards to the individuals health status
- Updating the IST during team meetings

Chart reviews, entry of medical appointments, scheduling, etc. are considered as standards of documentation of health care services and are not considered as a consultation.

WELLNESS ASSESSMENT IN ADVOCARE

Wellness Coordination includes the completion of the Wellness Assessment within Advocare including demographic information, recording of vital signs, significant health history, personal history, physician orders, risk assessments including completion of the medical/health section of the State's Risk Assessment Tool in Advocare, examinations, and evaluations.

Providers may use their own Nursing assessment form when completing the assessment away from a computer but all BDDS required information is to be entered into Advocare by the provider of Wellness Coordination.

DATA COLLECTION

Vitals must be collected and recorded in Advocare quarterly for all individuals, regardless of tier, receiving Wellness Coordination Services. The six (6) Baseline data points to be recorded are:

- Height
- Weight
- Body Mass Index (BMI)
- Annual flu vaccination date
- Annual physical date
- Annual dental visit date

PLAN DEVELOPMENT AND IMPLEMENTATION

Wellness Coordination includes the development, oversight and maintenance of a [Wellness Plan](#) as well as the development, oversight and maintenance of associated Risk Plans. The Wellness Assessment in Advocare identifies areas of the Wellness Plan to address.

The Wellness Coordination Plan will include a description of the individual, identification of the individual's needs and risks, the history and current status of the individual as well as interventions, monitoring guidelines, documentation guidelines, notification guidelines, training and education, and health outcomes. [The Wellness Support Plan Guidelines](#) details what is required in the Wellness Plan.

The Wellness Coordination Plan is to be developed within fourteen (14) calendar days of the finalized Wellness Assessment and is to be uploaded into Advocare by the provider of Wellness Coordination within five (5) calendar days and shared with the IST.

Associated Risk Plans are then reviewed or created within fourteen (14) calendar days for health and wellness needs identified within the Wellness Coordination Plan. There is no State requirement or template for what these plans will look like. Providers shall develop Risk Plans that are person centered and address the specific needs of an individual in all associated risk areas.

Once the Wellness Coordination Plan is developed, the Wellness Coordinator is expected to communicate with the individual's case manager and any applicable Wellness Coordination contracted dietitian, pharmacist, physician, or specialists to share Wellness Coordination Plan information and/ or gather any needed consultations.

All developed plans (Wellness Assessment, Wellness Plan, and associated Risk Plans) are to be reviewed by the support team at the quarterly meeting to address whether outcomes are being achieved and are appropriate.

TRAINING

The Wellness Coordination provider is responsible for the training of Direct Support Professionals to ensure implementation of Risk Plans within thirty (30) calendar days of development.

ONGOING SUPPORTS

Ongoing Wellness Coordination includes face to face visits per tier requirements; ongoing consultations with the individual's health care providers and the IST; reviewing and updating the Wellness Assessment in Advocare quarterly or when an individual's status changes; reporting on Wellness Coordination for team meetings; and coordination and monitoring of the waiver participant's Wellness Coordination Plan and the medical services required to manage his/her health care needs.

The Wellness Coordinator ensures the IST members work closely together to meet the individual's health and wellness needs. All related plans (Wellness Assessment, Wellness Plan, and associated Risk Plans) are to be reviewed by the support team at the quarterly meeting to address whether outcomes are being achieved and are appropriate.

In addition, the Wellness Assessment in Advocare serves as the quarterly report and must be reviewed/updated and finalized each quarter at least five (5) calendar days prior to the individual's quarterly meeting in order for the IST to be able to review the most recent data available. The Wellness Assessment can then be printed off for review at the quarterly meeting.

All plans will be reviewed and revised by the nurse as needed, but at least annually, when there is a new diagnosis, hospitalization or change in status. The plans will then be submitted to the team for review and implementation.

TIMELINES

The following table reflects the components of Wellness Coordination in regards to the timelines, frequency, documentation standards, and documentation upload requirements.

<i>Component</i>	<i>Timeline</i>	<i>Documentation Standard</i>
Wellness Coordination added to an individual's Cost Comparison Budget (CCB)	Provider has two (2) business days to contact the waiver participant and schedule an initial appointment.	Retained by the provider in the individual's records. The Wellness Coordination provider must upload into Advocare as well.
Initial meeting	Within seven (7) business days of beginning the service the provider meets with the individual and his or her guardian, if applicable, to identify medications, health care needs, doctor appointments, and any other relevant information needed to develop the waiver participant's Wellness Coordination Plan.	Completed in person. Providers may use their own assessment form when completing the assessment away from a computer but all BDDS required information is to be entered into Advocare by the provider of Wellness Coordination. Retained by the provider in the individual's records. Provider must upload the documentation into Advocare as well.
Initial Wellness Assessment	Entered and finalized within forty (45) calendar days of beginning service.	Completed in Advocare by the provider of Wellness Coordination; the finalized assessment can be printed and serves as the quarterly report.

Quarterly Wellness Assessment	Data will be carried over from the most recently finalized assessment, created quarterly, reviewed and updated, and finalized at least five (5) calendar days prior to quarterly team meeting.	Completed in Advocare by the provider of Wellness Coordination; the finalized assessment can be printed and serves as the quarterly report.
All assessment sections, excluding Vitals and Health and Systems Review of the Wellness Assessment	Carried over from most recently finalized assessment, reviewed and updated as needed during each CCB quarter.	Completed in Advocare by the provider of Wellness Coordination.
Vitals and Health and Systems Review sections of the Wellness Assessment	Data is required to be entered quarterly in Advocare.	Completed in Advocare by the provider of Wellness Coordination.
Wellness Coordination Plan	Created within fourteen (14) calendar days of initial finalized Wellness Assessment and updated annually. The Wellness Coordination Plan is also to be reviewed during quarterly meetings and updated as needed.	Wellness Coordination Plan is to be uploaded into Advocare's "Provider Documents Area" by the provider of Wellness Coordination within five (5) calendar days of initial completion and whenever updated.
Risk Plans	Created within fourteen (14) calendar days of initial Wellness Plan and updated annually. Risk Plans are also to be reviewed during quarterly meetings and updated as needed.	Risk Plans to be uploaded by the provider of Wellness Coordination into Advocare's "Provider Documents Area" initially within five (5) calendar days of initial completion and whenever updated.

Trainings	The Wellness Coordination provider is responsible for the training of Direct Support Professionals to ensure implementation of the Risk Plans within thirty (30) calendar days of development.	Retained by the provider in the individual's records. Provider may choose to upload into Advocare as well.
Visit logs, consultations, nursing notes, other documentation related to Wellness Coordination as outlined in 460 IAC 6-25-1		Retained by the provider in the individual's records. Provider may choose to upload into Advocare as well.

DOCUMENTATION STANDARDS

Wellness Coordination Services documentation shall include the professional standards applicable to the professional licensing requirements (registered nurse (RN) or a licensed practical nurse (LPN) under IC 25-23-1 working under the supervision of an RN) and the individual's Individualized Support Plan (ISP) as outlined in Policy Number: BDDS 460 1216 038 [Policy: Maintenance of Records of Services Provided](#).

Documentation standards include:

- Documentation of face-to-face visits (per tier requirements)
- Documentation of weekly consultations/reviews (per tier requirements)
- Other activities, as appropriate (outlined in 460 IAC 6-25-3 Documentation of health care services received by an individual):
 - The date of health and medical services provided to the individual.
 - A description of the health care or medical services provided to the individual.
 - The signature of the person providing the health care or medical service for each date a service is provided.
 - Additional information and documentation required in this rule, including documentation of the following:
 - An organized system for medication administration.
 - An individual's refusal to take medication.
 - Monitoring of medication side effects.
 - Seizure tracking.
 - Changes in an individual's status.
 - An organized system of health-related incident management.
 - If applicable to this provider, an investigation of the death of an individual.

- Services must address needs identified in the person centered planning process and be outlined in the ISP.
- The provider of Wellness Coordination will provide a report to pertinent parties at least quarterly. “Pertinent parties” include the individual, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities associated with the IST.
 - The Wellness Assessment in Advocare must be reviewed and finalized quarterly, serving as the quarterly report. There is no need for a separate written report to be submitted by providers via the “Provider’s Documents” area.

Providers may choose to upload documentation into the Advocare system that is not captured in the Wellness Assessment, Wellness Plan, or Risk Plans. All providers are responsible for maintaining documentation in the office and home files.

Service notes should include the date, time, and summary of service delivered. For instance, if a consultation occurred, the note should state the date it took place, the length of time, participants involved, and a summary of the discussion.

WELLNESS COORDINATION FREQUENTLY ASKED QUESTIONS

What is required for Wellness Coordination?

There are three (3) tiers, each with their own requirements. At a minimum, a Wellness Plan is to be developed by the provider based on the Wellness Assessment. The standards for each tier are outlined in the [Wellness Coordination service definition](#).

What is the Wellness Assessment?

The Wellness Assessment is a required activity in Advocare that is meant to support coordination of a participant's medical needs and to aid in the development of the individual's Wellness Coordination Plan.

Information entered into the Wellness Assessment in Advocare includes:

- Baseline data points:
 - Height
 - Weight
 - Body Mass Index (BMI)
 - Annual flu vaccination date
 - Annual physical date
 - Annual dental visit date
- Risk Assessment Tool
 - The Wellness Coordinator will not be responsible for completing the entire Risk Assessment Tool – only the portion related to Wellness.

What is a Wellness Plan?

The [Wellness Plan](#) is a guide to preserving an individual's health and current function, treating current health related issues, and/or improving the individual's health. The Wellness Plan is to be developed based upon the initial Wellness Assessment and is to be updated annually or whenever an individual's status changes. Components of the plan include:

- Interventions
- Monitoring
- Documentation
- Notification
- Training and education
- Health outcomes

How do providers know the health score of an individual they are serving?

The health scores can be found in the Advocare system through the Provider Portal. The health score is located in the Individual's Profile area (click on right) under "Algo/Allocation Information" and clicking on the "Raw Health Score" link.

How do providers sign up for the Advocare Provider Portal?

Contact Advocare directly to enroll in the Provider Portal at support@uadvocare.com

What is the required documentation for Wellness Coordination?

For documentation purposes the below information is required:

- Include Wellness Coordination Services within the Individualized Support Plan (ISP)
- The Wellness Assessment in Advocare
- The Wellness Plan
- Associated Risk Plans
- Documentation of weekly consultations
- Documentation of face to face visits
- Other activities, as appropriate outlined in [460 IAC 6-25-3](#)

What are providers of Wellness Coordination required to enter into the Advocare Provider Portal?

- The Wellness Assessment
 - Completed in Advocare initially within forty-five (45) calendar days of beginning the service
 - Reviewed and updated quarterly or when an individual's status changes
- The Wellness Plan
 - Created within fourteen (14) calendar days of initial finalized Wellness Assessment and updated annually.
 - Reviewed quarterly and updated annually or when an individual's status changes
 - Uploaded into Advocare
- Associated Risk Plans
 - Created within fourteen (14) calendar days of initial Wellness Plan and updated annually
 - Reviewed quarterly and updated annually or when an individual's status changes
 - Uploaded into Advocare

Is a separate quarterly written report required?

No. The Wellness Assessment in Advocare is reviewed and finalized quarterly; therefore, it serves as the quarterly report. The Wellness Assessment should be printed and provided to the Individualized Support Team (IST) for review during the quarterly meeting. It should also be uploaded into Advocare by the Wellness provider.

What does active involvement in all team meetings require?

The Wellness provider is expected to be actively involved in team meetings. This means either attending in person or providing updates to the IST on the individual's health status/outcomes, answering questions, and reporting on the individual's Wellness Plan during team meetings.

How will providers bill for Wellness Coordination?

For Wellness Coordination, the tier requirements for face to face visits with the individual and consultations with health professionals to discuss the diagnosis, prognosis, and treatment of a particular case must have taken place and be documented in the individual's records.

It is important to note that if any one of the required components for a specific tier is not met within the month prescribed, then the service will not be reimbursed. For example, if the nurse was unable to do a face to face visit twice during the month under Tier II then the service cannot be billed for that month. Consultations and face to face visits can still occur if the individual is hospitalized for a short time and the waiver remains in place in order to coordinate the individual's health care needs. For documentation purposes, each week's service and documentation will be attributed to the month in which the last day of the calendar week falls.

Approved Medicaid enrolled Wellness Coordinators can bill Indiana Medicaid in the same way as other Medicaid Waiver Claims. Billing for Wellness Coordination must be approved on the Notice of Action (NOA) and provided within the scope of the authorized tier. Providers are required to keep thorough records of the services.

What should providers do if they believe that an individual's health score is incorrect?

As medical events occur and/or a participant's medical needs change, the IST is expected to have the individual's health score reassessed and to ensure the appropriateness of services. If a team believes that an individual's health score is incorrect they should work with the entire team to submit a Budget Review Questionnaire (BRQ) to BDDS PARS Unit requesting a review of the health score. The case manager will submit the BRQ based on the team's agreement and recommendation.

BRQ's that result in a change to the health score, leading to a change in the tier, will be reflected in the Cost Comparison Budget (CCB) the month following the approval. No mid-month changes to the tiers on the CCB will be made.

If there is a change in the Notice of Action (NOA) during the month – either a change in the Wellness Score or a change in provider when will the change be effective?

All changes to Wellness Coordination NOA's will take place the first of the month following the approval. DDRS/BDDS would expect that the provision of service will continue until the end of the month.

Where should face to face interactions with individuals served occur?

In order to bill for Wellness Coordination Services the nurse must have a face to face visit with the individual being served based on the tier the individual has been placed in. Face to face meetings are a direct service that requires the nurse to meet one on one with the individual in a home or community based setting where the individual commonly spends time. It is expected that the nursing visits will take place in the natural environment of the individual so that observations and assessments of how their environment is affecting their wellness can be made. Face to face meetings must take place individually; not in group settings with several individuals receiving the same service from the Wellness provider.

What are the responsibilities of the Wellness Coordinator who does not work for the individual's Residential provider?

Wellness Coordination providers and Residential Service providers are key members of the individual's team. They each have clear roles and responsibilities as defined in the service definition within the [CIH waiver](#). It is the expectation of DDRS/BDDS that providers will work very closely together to meet the individual's health and wellness needs. This includes collaborating on visits to an individual's home and other environments where the individual may spend time.

How will the Bureau of Quality Improvement Services (BQIS) monitor Wellness Coordination?

BQIS will include Wellness Coordination in the same processes as all other services it monitors. Wellness will not differ from the current processes BQIS has in place.

What happens when an individual is in the hospital for an extended period of time?

If the individual is only in the hospital for a short time and the waiver remains in place, consultations and face to face visits can still occur to coordinate the individual's health care needs. If the Waiver is interrupted or terminated while an individual is hospitalized, billing cannot take place. Once an individual re-enters waiver services, all services on the NOA can resume.

Can an unlicensed person help a licensed person under this service?

Per the Centers for Medicare & Medicaid Services (CMS) approved service definition for [Wellness Coordination](#), only a registered nurse (RN) or a licensed practical nurse (LPN) under IC 25-23-1 working under the supervision of an RN meets the requirements to perform the service.

Where in Advocare do we submit billing for Wellness Coordination?

Advocare is not involved in billing for any service. Billing continues to be submitted via the same means as your organization currently bills for other services provided.

We need to make changes to Advocare permissions for several employees. Who can do that for us?

Anyone with administrative permission in their Advocare profile can make permission changes to employees' Advocare profiles. For more information on employee permissions, see the PDF Guide titled, "Provider Portal Admin Actions," available in the "Learning Resources" section of Advocare's Provider Portal.

I don't have an individual for whom I provide Wellness Coordination listed in the "My Individuals" dropdown. Can I add them?

Anyone with administrative permission can "attach" an individual to a particular provider employee, which ensures the individual is displayed in the "My Individuals" dropdown. Provider employees with supervisory permission can search for an individual via the "Manage Individual Waiver Participants" search option on the Home page. Contact the account's administrator to request an individual be added to your "My Individuals" dropdown. For more information on attaching individuals to employees, see the PDF Guide titled, "Provider Portal Admin Actions" available in the "Learning Resources" section of Advocare.

I provide Wellness Coordination to individuals receiving services from several of our organization's locations. How can I see all of their Advocare profiles?

You must have access to each location's Advocare profile in order to view information for individuals supported by different locations. Contact the location's administrator for permission. After permission is granted, use the "Switch Company" link, located in the "Account Management" area of the Admin Tools section, to go between the different locations. If the individual is located in the wrong location's account, contact the case manager and request the CCB be updated with the proper location.

I've used the "Manage Individual Waiver Participants" search function, and cannot locate an individual.

The individual's current CCB may not be updated to reflect the proper Wellness Coordination provider. Contact the case manager and request the CCB be updated with the proper provider location. If the CCB is correct, submit a "Contact Us" inquiry, located in the "My Supports" area, for assistance from Advocare.

I was able to do a Wellness Assessment for an individual last quarter, but can't start a new one now. Why?

If the "Create New Wellness Assessment" button isn't there, the individual's current CCB may not reflect Wellness as a service, or your organization as the provider. Ask the case manager to confirm the CCB is correct, and reflects your organization and location as the provider of the individual's Wellness Coordination. If the CCB is correct, contact Advocare for assistance via the "Contact Us" option in the "My Support" area of Advocare. Your Advocare profile may not include the proper permission(s) to access Wellness, or may have been changed since the prior quarter.

To view Wellness, your organization's administrator must assign proper permissions. Contact your organization's admin to confirm your Advocare profile permissions permit access to Wellness information, or for changes.

The individual may have chosen to discontinue Wellness. Confirm the status of Wellness as a selected service for the individual with the case manager. If additional assistance is required, contact Advocare for assistance via the "Contact Us" option in the "My Support" area of Advocare.